

## Guest Editorial

### Orthodontics in the year 2000

A constant decrease in the birth rate during the 1980's will have a considerable impact on orthodontic demands in pre-pubertal and adolescent age groups. Caries reduction and improvement of periodontal health will also continue to influence the work-load of the orthodontist. Less crowding, due to premature loss of deciduous teeth will reduce the number of extraction cases and increase the non-extraction cases. A recent survey in Switzerland shows that over the last 10 years orthodontic treatment for adult patients has increased by at least 100 per cent (Zurcher *et al.*, 1990). Stress-related occlusal breakdowns and TMJ problems could represent some 20 per cent of our activity in the future (Langlade, 1985).

The orthodontic specialty has always been at the service of children and adolescents, but it will become a major participant in complex multidisciplinary treatments where the orthodontist will be in charge of preprosthetic or pre-surgical treatment, or in collaboration with periodontologists. The orthodontic specialty will be at the cross-roads of most of the other dental specialties and, therefore, the future orthodontist who wants to keep up a successful private practice will have to spend an important part of the time he reserves for continuing education in the field of other specialties. This does not mean that he has to be able to place implants or perform osteotomies, but he has to keep up his knowledge in those fast-developing new specialties. Continuous co-operation with other specialists will produce the required background of knowledge necessary to advise patients concerning their specific problem. This additional knowledge in the fields of other specialties will widen the horizon of the orthodontist who will become, more and more, the co-ordinator of a multi-disciplinary approach.

Other factors will influence the specialty: computerized diagnosis in cephalometrics, in arch length and space analyses, in functional analysis of occlusion and cranio-mandibular disorders will become daily tools in an orthodontist's

practice. New technologies, 'alloys of the future', and others still dreamed of, such as hetero-transplants taken from a tooth bank, might be available.

However, the main problem orthodontics will be facing lies somewhere else.

Living in a society of well being, with the high standards of industrialized Western European countries, the political pressure of Health Politics will be influenced by the number of patients whose care will be taken over by a third party. Such an evolution has been particularly evident in the United States where only 1 per cent of all orthodontic patients were insured in 1965, close to 50 per cent in 1983, and in certain areas up to 75 per cent in 1990 (Dugoni, 1985). It is well known that it is easy to lead a small number of patients to a perfect result. It is just as easy to treat a large number of patients with a low standard of quality accepting many compromises. Quite a different situation and a real challenge will be the ambitious goal of treating a large number of patients to the required perfection at reduced fees! Does this mean utopia orthodontica? Hopefully not! I can only see two complementary solutions to face the facts in the future:

- (1) reduced treatment time;
- (2) delegation of certain procedures to well-trained auxiliary personnel working under the supervision of the specialist.

Reduced treatment time means treating the pertinent problem at the proper time. Early diagnosis of skeletal discrepancies may lead us to treat a maxillary protrusion before the age of 6, and mandibular deficiency between 8 and 10, thus eliminating in the first phase of orthopaedic treatment, the skeletal problem, and deferring a second phase, dealing with the finishing of the occlusion at a later stage. That is where the orthodontic team will be able to reduce the costs when part of the documentation, of the analyses, has been prepared by auxiliary personnel,

so that the orthodontist can take the necessary decisions and establish the treatment plan. If the chair-side assistants have been trained accordingly, they might be allowed to place the brackets and change archwires under the supervision of an orthodontist. In most European countries we are far from a legislation allowing such a delegation, but we have to be prepared that within Europe, at the year 2000, everything will change quickly!

It seems, therefore, the task of national orthodontic societies to prepare, together with national dental societies, a list of objectives with possible solutions of the problems our profession will be facing. This is not a task limited to 'leaders in the field', it has to be prepared from a base-line involving all the orthodontists seek-

ing an acceptable socio-economic solution for both, the patients and the profession.

Professor J-P. Joho

*Division d'Orthodontie et de Pédodontie*

*Section de Médecine dentaire*

*Université de Genève*

*Switzerland*

## References

- Dugoni A 1985 The future of our profession: Will we have one? Pacific Coast Society of Orthodontics Bulletin, Winter
- Langlade M 1985 Futurologie orthodontique. Rev. Orth dent fac 19/III/7
- Zurcher J M, Lang R, Joho J P 1990 Estimation de la demande future en soins orthodontiques et du nombre approprié d'orthodontistes pour la période 1989-1999. Rev Mens Suisse Odontostomatol 100/7: 835-840